Advisory Committee for a Resilient Nevada

Meeting Date: Thursday, January 13, 2022, 9:00 a.m.

I. Call to Order, Roll Call of Members, and Establish Quorum

Sheila Lambert, Department of Health and Human Services (DHHS), Director's Office, Grant Management Unit (GMU)

Members Present:

Barlow, Jessica; Collins-Jefferson, Brittney; Grady, Lilnetra; Gustafson, Ryan; Kaymar, Dr. Farz, Loper, Karissa; Monroy, Elyse; Patterson, Darcy; Saunders, Ariana; Sanchez, David; Sherwood, Laura; Wagner, Dr. Carla; Salla, Pauline; Sheehan,Cornelius; Maria, Cecilia,

Members Absent: Loudon, Katherine; Winbush, Quinnie, ;

II. Public Comment: *(Chairman David Sanchez)*

Chair Sanchez invited public comment.

Ms. Marcie Ryba serves as the Executive Director for the Department of Indigent Defense Services. This is her second meeting. Ms. Ryba said that The Department of Indigent Defense Services is tasked with oversite and support of indigent defense providers throughout Nevada. Indigent Defense Providers are public defenders and are essential workers who have worked decades on the front lines providing constitutionally required representation to thousands of Nevada's most at risk; vulnerable adults and juvenile populations. Indigent Defense Services represent those struggling with poverty, mental and behavioral health issues, substance abuse, (including opioid addiction), and a combination of conditions. Most of these people have no idea how to qualify or ask for social services needed. Ms. Ryba promotes what is needed in rural Nevada is the ability to identity needs of these people and connect them to resources. This Department is working to build a Holistic Resource Center, (HRC). There is no funding for this project. Holistic Defense is an evidence-based practice emerging in 1990's as a paradigm for legal representation of indigent clients. The Holistic Defense model is based on the idea that to be an effective advocate, public defenders must adopt a broader understanding of the scope of their work. Defenders must not only address the immediate case at hand, but also the collateral legal consequences of criminal justice involvement. Such as loss of employment, public housing, custody of children and immigration status. Underlying life circumstances and non-legal issues often play a role in driving clients into the criminal justice system. These include substance addiction, mental illness, family, and housing instability. The HRC also provides aid at intercept level two on the sequential intercept model, at this

point, is seems like assistance is being provided at incept three. The goal of HRC is to create a system in which appointed indigent defense counsel across the state have the same resources for their clients as attorneys and Urban Indigent Defense offices. The HRC will facilitate holistic treatment of Nevadas' at-risk population who fall into the criminal justice system through early identification and effective allocation of resources throughout the state. The HRC is a critical piece of the opioid puzzle and public defenders are uniquely positioned to assist with this problem. We hope that you consider the HRC when prioritizing how to allocate this funding.

III. Discussion and Possible Action to approve the minutes from the November 18, 2021, Meeting. *(Chairman Sanchez)*

Chair Sanchez called for approval of the minutes for the November 18, 2022, meeting. Meeting minutes were approved unanimously no changes.

IIII. Presentation and Discussion from Mercer on the status of preliminary results of the draft needs assessment in compliance with the Senate Bill (SB) 390 legislation which will be codified in NevadaRevised Statute (NRS) 433. This serves as a work group item for input, engagement and recommendations from ACRN.

(Dr. Courtney Cantrel, Kathy Nichols, and Jordan Bublik)

Dr. Courtney Cantrel provided an overview of the needs assessment including the background of methodology, and the senate bill that authorized and the assessment. This included looking at the impact of opioids, the risk factors, both individual and an at a system level that's driving the opioid crisis. In addition, they considered all Substance co-occurring conditions and suicide impact of the epidemic and current plus potential resources and programs that we have seen with in Nevada. First is the background and methodology. Around 2011 to 2015 is when opioid overdoses and prescribing rates are on the rise. In 2015 Nevada had the second highest prescribing rates of hydrocodone and oxycodone in the United States. The Obama Administration began funding to combat the crisis in early 2016. With federal funding, Nevada began to address the crisis with a statewide opioid conference. In 2017 Nevada implemented the Drug Enforcement Administration in high trafficking areas called HIDTA to determine those critical drug trafficking areas. The rates of methamphetamines and fentanyl drastically increased by 2019. Nevada saw opioid overdose deaths with stimulants as a contributing factor. Nevada experienced another increase in 2020 which tracks with the pandemic. There was a sharp increase in poly substance overdoses and elicit pill consumption which brings us to present. This sparked more federal funding and attention to the opioid crisis. In 2018 things began to get better and you can see those improvements. Then the pandemic hit, and it all has gone out the window. Senate Bill 390 established the Fund for a Resilient Nevada within DHHS. This assessment is to determine how to create state plan to combat the opioid epidemic and how to set priorities for funding. The needs assessment must use the damages report and the opioid litigation. It must use qualitative and quantitative data with evidence-based practices. We are working with ACRN to receive feedback from you regarding needs and priorities to include those in the report. To develop that needs assessment we have reviewed applicable legislation and different seminal documents from the state giving key data sources and received input from various state agencies. The opioid impact has been tremendous despite improvements in 2018. Nevada still ranked 28th in opioid overdose deaths and 20th in opioid prescriptions in 2019. In 2020 the U.S. saw 30% increase of opioid related overdose deaths. In Nevada from 2019 to 2020 opioid related overdose deaths increased 76%. There was an increase in fentanyl related emergency department encounters by 227% and opioid emergency encounters by 26%. Sub populations within Nevada have experienced increases in opioid use. Self-reported use of heroin and opioid use among pregnant woman has quadrupled. The top age impacted by opioid overdose deaths in 2020 is ages 55-64 and the top race or ethnicity is white male plus top education is high school diploma. Fentanyl was the top contributor with ingestion as primary route. Co-occurring substance, opioid and methamphetamines occurs 26% of the time. Clark and Washoe counties are top counties with overdoses. From 2019-2020 Nevada's northern and southern regions experienced increased overdosed at 60%. Southern Nevada tripled its total. Northern Nevada saw 164% increase

in fentanyl deaths. Southern Nevada fentanyl deaths increased 257%. Overdose deaths in Southern Nevada increased by 146%. At county level, Churchill, Lyon, Lincoln, and Carson are the top five counties of highest opioid overdose deaths.

Nevada has largest percentage of uninsured unauthorized immigrants in the region. Nevada has 27 federally recognized tribes; 97% which are rural, and 30% live in poverty. Hispanics face higher rates of overdose deaths. Information is sparse regarding health equity, and we will have to look at the national data. Minorities don't get the same quality and access to treatment. The things that are not known will have to be extrapolated from national studies. Nevada is a target for drug trafficking with major transportation highways bordering with other drug trafficking states like California and Arizona. The pandemic slowed the pace of drug trafficking, but drug dealers turned to the Dark Net to sell, purchase drugs and commodities. Nevada HITDA assess opiates will continue to be a high drug threat. There are so many risk factors for the opioid problem to worsen. Not having enough prevention programing, that's not unified with established outcomes, or not having one plan for it, is a factor. There are some great programs, but they're not funded well enough throughout the state so that everyone can take advantage of those benefits. The harm reduction programs are limited to certain places and need to be expanded. Recovery support depends on parent education. Transportation and housing, help keep someone in recovery. Not having enough providers is a problem. Lack of quality treatment throughout, as primary care providers could be proactive to identify and refer people to treatment. Individual risk factors. The biggest risk factor is Adverse Child Experiences, (ACES). Most start using substances at 13 years. A trauma in youth that needs surgery or therapy. Those who lack vocational opportunities. Nevada Vulnerability Assessment was conducted in 2019 to evaluate risk of opioid overdose. The vulnerability assessment found that Nye, Lyon, Story, Mineral, Washoe, and Carson City counties are the most vulnerable. Polly substance and co-occurring disorders and suicide impact. There is less information. There are co-occurring conditions such as Behavioral and Physical health which include mental illness, suicide, and sexually transmitted infections. The currant potential resources or programs in Nevada. Providers are not operating up to capacity in more rural areas. State is considering using more mobile providers with medication assisted treatment. The reason they are not operating to capacity is that maybe we are not identifying people. The public needs to know how to get through the front door of treatment when they are struggling. SORES Funds are being used to address poly substance use. Harm Reduction is being utilized. Workforce Shortages, specialized practitioners is substance use and short to long term residential detox needs. Certified training program for community health workers can be utilized to connect members with services and community resources that can be expanded. Prevention and Recovery need to include both suicide programming and access to those social determinants of health.

Nevada needs a recovery system which allows individuals to access transportation to attend treatment and resources to maintain stability. Local interventions are Mobile Outreach Safety Teams, (MOST), and Forensic Assessment Services Triage Teams (FAST). Parenting as a Path to Recovery; there is a lack of unified neonatal programming in the state. The University of Nevada Las Vegas Ackerman Center, and the University Nevada Reno Nevada Center for Excellence in Disability (NCED), are designed to meet the complex diagnostic and behavioral needs of youth affected by in-utero exposure to substances of abuse, specifically opioid. Nevada has used the John Hopkins Bloomberg School of Public Health recommendation and guidelines on best practices for further developing our system. For future directions, we're looking at our continued data collection and additional data sources. we are looking at tribal and minority needs. UNLV is working on the qualitative surveys for more information. We would like to know your feedback.

Chair Sanchez asks for feedback. Ms. Monroy states her other request is that some slides had data sources, and requests that all data science would be helpful. Ms. Cantrell agrees.
Ms. Grady speaks about the needs assessment and asks if specific area codes could point out counties that are impacted. Ms. Grady also asks for data on cocaine use with opioid use disorders. Ms. Grady adds that data is needed for teenagers who are impacted by the opioid crisis and childhood

trauma. Ms. Cantrell believes that childhood trauma is part of ACES.

Ms. Saunders speaks regarding housing and suggests getting data, not just housing interventions, but data of those experiencing homelessness, especially those in shelters or on streets. She states that there are 3 COCs and offers help connecting to them.

Chair Sanchez states that there is a specific population that can access primary care as a treatment path. Chair continues saying that other minority populations don't tend to use that as often because they don't have primary care. Chair suggests looking at what it would be to have community care or places people go to seek medical attention. Chair states that that those without insurance who go to low-cost community providers and say they do not claim a primary care provider. Chair suggests getting data from those community providers and not just leave it open to Primary Care Physicians. Ms. Cantrell agrees with recommendation to look at how rural health clinics could also be MAT providers. Chair Sanchez asks if there is oversight of opioid prescriptions. Ms. Nichols states that it is being tracked closely.

Chair Sanchez states that it sounds like we have an infrastructure plan, which needs to supplement existing programs and practices to be effective or more effective. We need data that shows that these programs and practices are working. Chair asks if the state has some type of blanket implementation to say that what is existing, and this is our agency that works to support opioid overdose deaths or areas that have opioid overdose deaths. Chair wonders if this is too broad or is that what is being created?

Ms. Cantrell believes that the state plan is going to become that. She states that there are needs assessment which has three priority areas, and other priorities that will be found in data.
Ms. Loper comments that more information is needed on workforce shortages, that's why they can't respond as well in Nevada and to fold more of the workforce issue into the needs assessment.
Ms. Cantrell states that there is a huge a workforce report between 2018 and 2020 that has been appended to the infrastructure assessment report the state has, where many recommendations are pulled. Ms. Loper states that she would look at that more comprehensively.

Ms. Collins-Jefferson asks when looking at co-occurring mental health with substance use, as clinicians, is it being broke down into percentages pertaining to depression, and anxiety that will give insight on specific mental health disorders impacted by opioid use. Ms. Cantrell states that the reports do not get that granular because the data is by survey or claims data.

Ms. Nicholes says what was provided in the overall demographics which is focused more on age and gender plus she does not see anything more Nevada specific. Ms. Collins-Jefferson asks if assessments are being done for risk factors of someone becoming addicted or dependent. Ms. Cantrell contends that there is a Controlled Substance Reporting Program that is a statewide database where those drugs are listed and offers the provider a person's history with that drug.
Ms. Monroy reminds that this is not just a practice but law. Ms. Bublik states that some of the data is outdated but research will continue to finalize the needs assessment with the most recent data sources. Ms. Nichols affirms that there are restrictions and legislation regarding prescriptions for drugs such as morphine. Ms. Collins-Jefferson is concerned about the population of minorities that are using substances and not seeking treatment going unnoticed. Ms. Collins-Jefferson asks if there is an assessment for those populations? Ms. Cantrell believes this is one of the things that could be added to the recommendations. Ms. Bulbik agrees that there are gaps in data and with sub populations there needs to be better data collection. Ms. Salla expresses interest in the juvenile data and it needs to be included due to the increase in adolescence with opioid overdoses. Ms. Monroy agrees that juvenile data is missing in this summary and sources can be pulled from the Department of Education. Ms. Monroy suggests a need for an assessment of current federal grants on the prevention, intervention, and treatment which are set up for specific populations or specific substances. Ms. Lambert reminds the committee that their role is to identity the needs of the State of Nevada,

afterwards that's when the grant management unit will look at what isn't funded. The focus is on needs. Ms. Monroy says that current resources exist in the community to meet that need and a population or a substance that is currently flush with resources will determine if that need is a need or not.
Ms. Lambert states we focus on the needs that are in the community, and then funding review is part of the process. Chair Sanchez believes that it needs to be kept simple and come up with a list of priorities that need to be addressed.

Dr. Wagner advocates for the people who were using drugs. Dr. Wagner wonders how people can be incorporated who are accessing the harm reduction services and people who are at risk for overdose. Dr. Wagner expresses its importance to understand the distance people travel to providers or to their needle exchange. Dr. Wagner states that Federal dollars cannot be used to buy needles for the exchange program. Dr. Wagner shares that she is working with a colleague who has completed analysis of the impact of opioid prescribing practices using data from the Prescription Drug Monitoring Program, with sophisticated statistical methods that can measure how things have changed overtime. Dr. Wagner believes it helpful to pull resources from experts in ACES, Trauma, and informed care. Ms. Cantrell said those different roles would have access to people in treatment in ways that they wouldn't have.

Dr. Wagner adds that it is not just those people in treatment but also those accessing the service. Ms. Nichols adds that there are people who don't have access to services, and this should be discussed. Ms. Cantrell confirmed that a survey did go out to homeless shelters, and to those who do outreach in the community to people who never enter treatment. Dr. Wagner responds that in terms of her research, they try to solicit opinions of people who are accessing services to find out what is going on with them. Dr. Wagner adds that there are studies in the field looking at methamphetamine use and how it is combined with opioids. Chair Sanchez asks Dr. Wagner to provide the findings from that research to Mercer Team or the committee which would help guide our decisions or perspectives.
Dr. Wagner assured that the input could be provided, after knowing what is meaningful.
Chari Sanchez asks committee if there is something specific, they would like to see that Dr. Wagner bring forward. Chair Sanchez suggests having Mrs. Lambert reach out to find out what information would be relevant to in guiding committees' priorities. Ms. Loper believes that qualitative information would be important as to understand how someone decides if they want treatment or stop using, and what steps they are taking based on their demographic. Chair Sanchez suggests that maybe they could support an environment that get people to seek recovery. Ms. Grady believes that people don't know about what they are offering or that insurance is not an issue. Ms. Cantrell states that will be in the last section they are writing. Dr. Wagner confirms that people don't know of all the things that are available. Ms. Monroy states, the need to know about what's currently being funded because it's going to tell us where the gaps are.

Ms. Lambert disagrees that looking at what isn't being funded is going to reveal the gaps and continues to say that funding is important but the focus is the needs assessment. Ms. Lambert advises committee that this is not one and done, and we will continue to define needs. Chair Sanchez agrees that the committee should stay focused on needs and what is perceived to be priorities to move forward.
Ms. Saunders agrees with Ms. Lambert when needing more context but not sure how comprehensive it needs to be. Ms. Saunders states that there needs to be an understanding of services that are available, and those gaps in community services to be addressed. Ms. Saunders said that just understanding what is being offered is going to give us a better idea of what's eligible because there is a lot of new funding. Ms. Saunders adds in order to be able to prioritize where there's need there has to be information to give committee context.

Ms. Lambert asks the committee to refresh themselves on SB390 and look at what can be funded. Ms. Lambert states that as the needs assessment goes along it will identify the gaps and where the resources are within the community. Ms. Lambert points out that after the state is done with needs assessment, there are funds allowed and looking back to the legislation, it lists what cannot be funded.

Ms. Nichols points out that section five of needs assessment and the slides, is pulling out some of those pilots. Ms. Nichols continues to say that it's not necessarily by a funding source but what's available. Chair Sanchez states that the difficulty with existing funding sources is understanding what is allowed to and not allowed to advocate this money to be used for. Chair Sanchez adds that in moving forward the committee is going to have concerns about what is being supported, and what is going to be called out in this needs assessment in which they are to use their experience.

Ms. Lambert agrees that Dr. Woodard, the legislative committee members, and Attorney General's Office made up the diversity of this committee whose members were selected to represent all counties and were selected for a specific role as individuals with life and work experience.

Dr. Kamyar asks if the Mercer Team would be able to assign an impact score of certain things, that have been identified whereas the committee could tackle the things that are high impact. Dr. Kamyar continues in his request to assign some sort of relevance or impact fact to the items identified.
Ms. Cantrell contends that the legislative requirement for the needs assessment is that qualitative and quantitative data must be evidence based. Ms. Cantrell states that an impact score, given the time and resources would be hard to do. Ms. Cantrell affirms that Mercer can show the gaps and then those would have to prioritized. Ms. Cantrell believes that there's going to have to be a bit of subjectivity, but an overall needs assessment has to stick very explicitly with the qualitative and quantitative date.
Ms. Bublik anticipates implementing a scoring scale that Mercer does use for needs assessments which will provide an impact scoring as well as an acuity of need. Chair Sanchez believes that the committee can trust and adjust as they move forward with what Mercer brings to the table.

V. Presentation of Informational Meeting to calendar the next two ACRN Meeting Dates.

a) February 9, 2022, 1:00 – 2:30 p.m.

b) February 24, 2022, 10:00 – 12:00 p.m.

Ms. Lambert reminds committee of two meetings in February, in which they will be getting into a lot of specific detail and begin getting feedback for prioritization. Ms. Lambert states that the Mercer Team will be presenting to the search team on the 19th which will include an overview of the comments that came today at this meeting, and they'll be getting those additional surges which is part of identifying priorities for the state. Ms. Lambert hopes that everyone will be available and if members are unable to attend, please let us know because as soon as we get the needs assessment the next step is to do the state plan. Ms. Salla asks if there is a way to get the calendar invites sooner.
Ms. Lambert said she will do her best in hopes to have new hires soon.

Chair Sanchez recognizes the pressure of staff transitions and Covid. Chair Sanchez motions to move to agenda six asking if there is anything that needs to be added or addressed at this point.

VI. Discussion for Requests from the Chair or Committee Members on Information for next or futureAdvisory Committee Meeting.

Ms. Loper thinks it would be interesting to hear from those regional health boards, on their activities and work. Chair Sanchez said he is not sure when it will happen but things it should happen at some point. Ms. Lambert suggests reaching out to see what the availability is and then can let you know at a future

meeting. Ms. Lambert said that they will also have the Office of Minority Health and Equity share the equity tool that will be applied to the recommendations at an upcoming meeting.

VII. Public Comment #2:

Ms. Ryba said she noticed in the state agencies that gave input there was no public defenders that were contacted for that report. Ms Ryba said that the Department of Indigent Defense would be happy to talk with Mercer about certain needs in which they could assist and she is asking for that opportunity to come to the table. Chair Sanchez thanks Ms. Ryba and asks Mercer to connect with Ms. Rybas team because that component looks as though it could turn many lives around. Ms. Lambert shares that the Department of Public Behavioral Health under the Bureau of Prevention currently has a notice of funding opportunity, which includes criminal justice as a priority focus area.

Ms. Monroy states just put a link in the chat for everyone to see her program, and the program is having a virtual town hall with the office of Minority Health on January 27. Ms. Monroy said that they will talk about black indigenous people of color to hear about their barriers and challenges in accessing treatment.

VIII. Adjournment 1:55 pm Thursday January 13, 2020